City of Milwaukee Health Department

16716

Medical History and Consent to Receive Novel H1N1 Influenza Vaccine

PLEASE PRINT CLEARLY

Health Insurance? ☐ Medicare ☐ Medical Assistance (BadgerCare, Medicaid, Etc.) ☐ Private ☐ No Health Insurance

SSN # _____

Name of Insurance _____ Insurance#/ForwardCard#: _____

Part I. Personal Information for Person to Receive Vaccine

Last Name | First Name | M.I.

Street Address | Apt/Unit Number

City | State | Zip code | Primary Phone

Date of Birth (MM/DD/YYYY) / /

Gender: Check One ☐ Male ☐ Female

Age _____ in (check one) ☐ years ☐ months

Race: You may mark (X) more than one:

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: You may mark (X) only one:

☐ Hispanic or Latino/a

☐ Not Hispanic or Latino/a

For people younger than 18 years of age:
Name of Parent or Guardian

Last Name | First Name | M.I.

Mother's Maiden Name

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Screening

Clinic Location / Site Code: _____ Eligible for vaccination today: ☐ Yes ☐ No

Vaccines eligible to receive: ☐ Sanofi Pasteur ☐ Novartis ☐ Medimmune ☐ GSK ☐ CSL

Screener's Signature _____ Date: _____

Administration

Manufacturer:

☐ Sanofi Pasteur ☐ Novartis ☐ Medimmune ☐ GSK ☐ CSL

Dose: ☐ .2 ml(nasal) ☐ .25 ml ☐ .5 ml

Site: ☐ NASAL ☐ RD ☐ LD ☐ RT ☐ LT

Lot # (Place sticker here)

Administered by:

Date: / /

Name of Person Receiving Vaccine _____
(Last, First, Middle Initial)

Age of Person Receiving Vaccine: _____

Part II. Medical Information: Mark (X) "Yes "or "No" for questions 1-14

Is / Does the person receiving the vaccine today:

1. Sick / running a fever?	❒ Yes ❒ No
2. Have a serious allergy to foods, medications, ointments, latex, eggs, gelatin, Thimerosal (mercury-containing product) or an other substance?	❒ Yes ❒ No
3. Have a history of seizures, convulsions, epilepsy, Guillain-Barre or any other nervous system or brain problems?	❒ Yes ❒ No
4. Have a history of serious problems or reactions (including neurological symptoms) with previous immunizations?	❒ Yes ❒ No
5. Have a bleeding disorder?	❒ Yes ❒ No
6. Have asthma, or had one or more episodes of wheezing in the last year?	❒ Yes ❒ No
7. Have long term health problems such as heart, lung, kidney or liver disease, or metabolic diseases such as diabetes?	❒ Yes ❒ No
8. Have a weak immune system (including HIV, AIDS, cancer, kidney disease, leukemia, or medications such as steroids)?	❒ Yes ❒ No
9. Have close contact with anyone with a severely weakened immune system that requires a protective environment (for example, anyone with a recent bone marrow transplant)?	❒ Yes ❒ No
10. Pregnant?	❒ Yes ❒ No
11. A child or adolescent on long term aspirin therapy?	❒ Yes ❒ No
12. Received any other vaccines within the last 28 days?	❒ Yes ❒ No
13. Currently taking antiviral medications?	❒ Yes ❒ No
14. Have a serious blood disorder (such as sickle cell)?	❒ Yes ❒ No

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Education: Medical Information Comments	

Part IV. Consent

I have been given a copy and have read about INFLUENZA and the INFLUENZA VACCINE. I believe I understand the benefits and risks of the vaccine. I have been instructed about reasons a person should not get this vaccine, and I (or the person named above, for whom I am authorized to make this request) am not experiencing any condition that would be a reason to not get the requested vaccine. In accordance with Wisconsin State Statute 252.04 and Chapter HFS 144, I understand that all immunization-related information may be shared with Milwaukee Public Schools and the State of Wisconsin. I consent to entry of client's vaccination records into the Wisconsin Immunization Registry. I agree to allow immunization information to be released to our family physician, any medical referral service, and/or insurance companies. My signature below also permits the City of Milwaukee Health Department (MHD) to bill Medicaid (Title 19) or Medicare for all applicable immunization services. I will not be asked to pay for any services provided by the MHD related to this vaccination, and I have been offered a copy of the MHD Notice of Privacy Practices.

Patient/Legal Guardian Signature _____

Date _____